Achieving Improving Quality in Liver Services (IQILS) accreditation – lessons learned from one unit's experience

Authors: Sreelakshmi Kotha,[A] Giovanni Tritto,[A] Eleni Theocharidou,[A] Terry Wong,[A] Bo Wang[A] and Philip Berry[A]

ABSTRACT

In 2017 the Royal College of Physicians launched a voluntary accreditation process supported by British Association for the Study of the Liver (BASL) and the British Society of Gastroenterologists (BSG) to improve the quality and consistency of liver services across the UK and Ireland. This article describes the approach that we took and the challenges that we met on the way to achieving accreditation.

KEYWORDS: IQILS, accreditation, liver services

DOI:10.7861/clinmed.2022-0452

Introduction

In 2017 the Royal College of Physicians (RCP) launched a voluntary accreditation process supported by British Association for the Study of the Liver (BASL) and the British Society of Gastroenterologists (BSG) to improve the quality and consistency of liver services across the UK and Ireland.[1] Accreditation is granted in two stages.[2] Level 1 requires evidence of essential organisational and infrastructural arrangements delivered to an acceptable quality, and is agreed following virtual or site visit assessment. Level 2 demands sustained high quality services, patient involvement and achievable long-term strategic aims. Level 2 assessment requires a 1-day site visit by a team comprising a doctor and a nurse who work in a liver unit and a lay assessor representing the patients' perspective. An overview of the accreditation process is shown in Fig 1. Ongoing accreditation is dependent on an annual review process, ensuring maintenance of standards with a site assessment every 5 years. This article describes the approach that we took and the challenges that we met on the way to achieving accreditation.

Description of Guy's and St Thomas' liver unit and overall management structure

GSTT is the largest NHS Foundation Trust in the UK, with services extending into the community and to several distinct sites across London. Hepatology, therefore, occupies a relatively small niche within the organisation (Fig 2). There is autonomy within clinical groups and also within directorates to redesign services; therefore, although the Trust executive were made aware of the Improving Quality in Liver Services (IQILS) application, the decision to proceed required local sign off only. Within the gastroenterology department there was latitude to change clinic profiles and develop a distinct hepatology identity (for instance, by encouraging service managers to place only liver patients in the clinics). Current hepatology establishment comprises six full time equivalent hepatology consultants, four specialist nurses (one hepatitis nurse, two hepato-pancreatico-biliary (HPB) nurses, and one ward hepatology nurse), two specialist pharmacists, one hepato-biliary fellow, one hepatology fellow and the inpatient ward team.

Initial preparations

The need to develop bespoke hepatology service at our hospital was identified and the department was already initiating plans to achieve this when there was a national announcement by the RCP that liver services would be accredited. As IQILs aligned with the department's aspiration to develop hepatology services, the clinical lead and senior colleagues made an early decision to aspire towards IQILS accreditation. Strategic buy-in was achieved with the senior managerial team and the IQILS registration fee was funded. A business case for a locum hepatologist was submitted successfully and the appointee led on the IQILs accreditation. The importance of having a named person in charge of the process was recognised early and clear delegation and ownership of various sections of IQILs was achieved. A hepatologist and clinical lead attended a 1-day, in-person IQILS orientation workshop to fully understand the requirements of the program. The learning was summarised and disseminated to the rest of the group during a hepatology business meeting. Business meetings, hitherto held rather haphazardly, were scheduled regularly (monthly) in order for coordination and agreement among team members to be achieved. The lead hepatologist for IQILS acquainted themselves with the online submission portal. At monthly business meeting a clear agenda was drawn up, tasks identified and delegated with a clear target time to achieve each task based on the six domains of IQILs (Domain 1: Leadership and operational delivery; Domain 2: Person-centred care; Domain 3: Risk and patient safety; Domain 4: Clinical effectiveness; Domain 5: Workforce; Domain 6: Systems to support clinical service delivery). Minutes were recorded.

Authors: [A]consultant hepatologist, Guy's and St Thomas' NHS Foundation Trust, London, UK

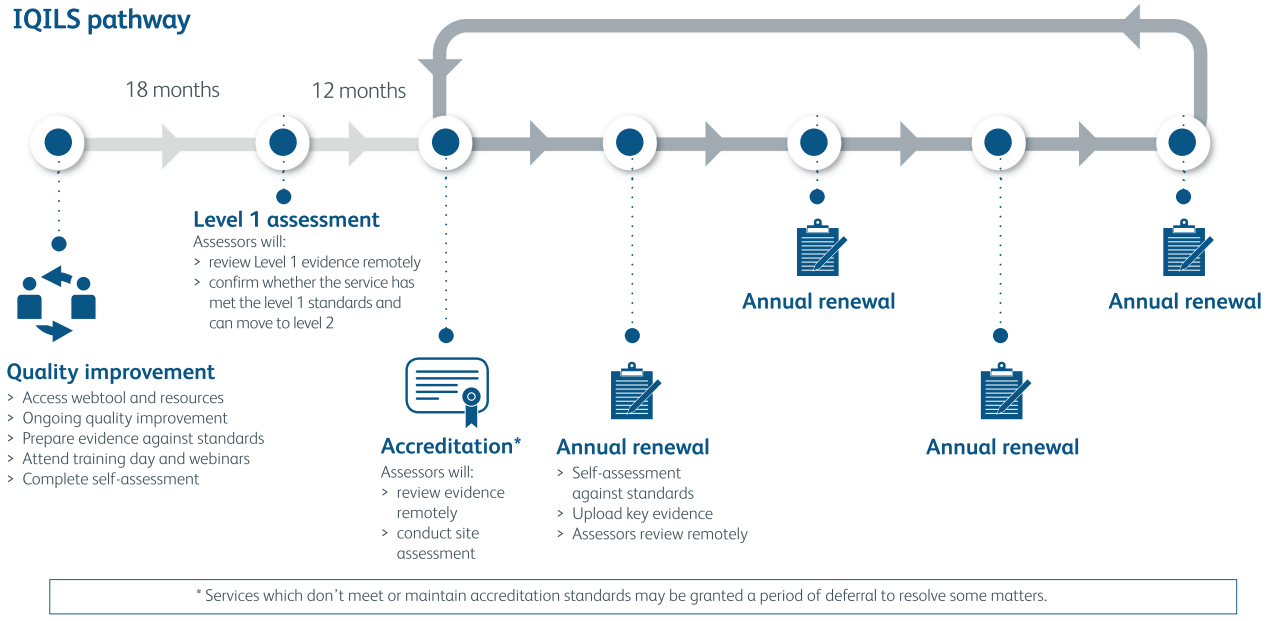

Fig 1. Route to liver services accreditation. Reproduced with permission from the Royal College of Physicians.

Breakdown of challenges and goals

The following list of priorities and tasks was developed after initial assessment of IQILS requirements.

- Scope the current service
- Gap analysis
- Engage management

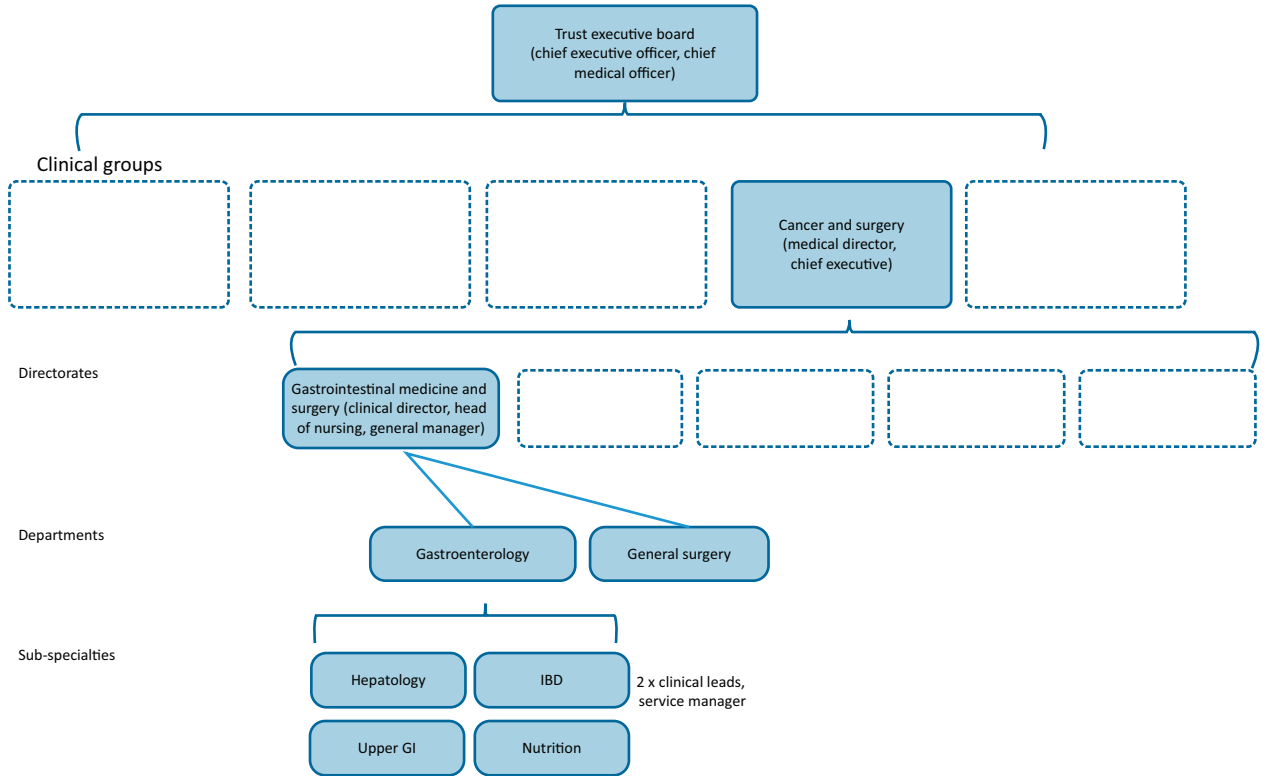

Fig 2. The organisational and management structure at Guy's and St Thomas' NHS Foundation Trust.

- Engage patients
- Engage community-based colleagues
- Expand the hepatology day unit
- Prepare a strategy to address demand and capacity
- Create and upload evidence to the database
- Prepare for and host the site visit

Completing the above steps required motivation and persistence. Because the activities are not directly related to clinical activity, an argument needs to be made for time to be allocated. In our experience, time was found without dropping existing activity, and we certainly learned that a job shared is a job halved. Clear delegation and ownership of duties was important, though a single person should maintain overall understanding of how much progress is being made.

Scoping the current service

The breadth of activities and services provided by the hepatology group was documented. This included a full census of consultant, nurse-led and pharmacy-led clinics, and delineation of patient pathways from the community, emergency department/acute medical unit, internal referrals and tertiary referrals. Specific administrative pathway coordinators compiled a list of patients who were overdue for follow-up for the department and clinicians reviewed these lists virtually and arranged appropriate management plans bringing the numbers down significantly. A retrospective record of teaching activities and research output over the previous 3 years was created. These were collated into a shared hepatology files as a foundation for level 1 submission.

Carrying out gap analysis

Major gaps between current activity and necessary activity for certification included regular patient engagement, evidence of responsiveness to patient feedback, an easily contactable helpline for patient queries, hepatology-specific mortality and morbidity reviews, audits for clinical and outpatient metrics, liver-specific governance structures and establishment of a good interface with primary care. Establishing hepatology specific pathways in department where hepatology was embedded within a larger gastroenterology department was challenging. In general, the standards required of IQILS aligned with the strategic priorities of the Trust, which in turn reflect key lines of enquiry by the Care Quality Commission (eg clinical effectiveness, patient safety, attention to workforce skill mix and development); however, achieving them required acceleration or prioritisation in certain areas. The best example of this was 'person-centred care', including patient involvement in changing or designing models of care. Although the Trust has a well-developed patient experience department, the questionnaires in use were not focused on liver care. Additionally, while the Trust aspired to see patient representatives involved regularly in meetings, these were not established in more than handful of areas. The IQILS process resulted in rapid establishment of patient fora and a change in questionnaire design such that responses were specific to hepatology rather than all of gastroenterology. At an operational level, it was necessary discuss specific issues such as a responsive 'Did Not Attend' policy and robust continuity when patients are transferred into or out of other hospitals.

Engaging management

Engagement with senior management was predicated on the potential benefits to the department and the Trust to be derived from accreditation. These included enhanced reputation for the department and entire institution, increased patient confidence and choice, quality assurance of the service, providing robust evidence to regulators such as the Care Quality Commission (CQC), and the potential, ultimately, for higher-tariff services to be commissioned. Awareness that the RCP expected all hospitals delivering liver services to be accredited over time was raised with clear messaging to emphasise that support would be required for a successful submission. Comparisons with the endoscopy accreditation process, Joint Advisory Group (JAG), made it easier to understand the quality improvement imperative behind IQILS. This also originated in the RCP and is now widely accepted as a necessary process for endoscopy units nationally. In terms of a sustainable business model for additional support required, deployment of existing resources allowed for the necessary focus on liver services – the IQILS coordinator being the only exception. Funds for this post were secured after IQILS accreditation; this demonstrates the need to clinicians to organise themselves such that one or more of them has time to initiate the process.

Engaging patients

Previously, patient feedback comprised 'family and friends' questionnaires (not specific to the liver service), informal comments or emails, visits to the patient advice and liaison service (PALS) and formal complaints. We developed a hepatology-specific questionnaire for distribution in clinics in order to maintain a continuous stream of feedback. Later, this questionnaire was developed into an electronic format, and could accessed on smart phones via a QR code. This required liaison between a nurse specialist and the IT department. Additionally, regular patient forums were instituted. During the COVID-19 pandemic these were necessarily conducted via Teams, although the group observed that this was probably the preferable medium as some patients, especially tertiary referrals, lived some distance away. The forums were not highly structured. A consultant asked each patient present to make general comments, be they positive or negative. Ground rules were established around confidentiality if information about patients' diseases was shared. Our observation was that patients agreeing to attend had generally positive things to say about the service, and were more than willing to share their observations. One limitation was that patients all spoke English as a first language and were from higher socio-economic groups. We identified a challenge in successfully recruiting patients from harder-to-access areas, including those non-English speaking (eg hepatitis B patients in our area) or those with less stable domestic situations. We conducted patient forums three times per year and minuted the comments.

Another area identified for development was accessibility of the department to patient queries. A dedicated liver helpline via email and telephone was set up. The email queries had a response time of 24–48 hours and telephone queries were answered on the same day. The email contact was embedded at the end of all clinical letters and has received excellent feedback from patients.

Engaging community-based colleagues

Engagement with primary care physicians was through development of pre-referral guidelines and delivery of educational sessions. The IQILS process afforded an opportunity to collate all existing guidance and update where necessary. The main areas of activity were for non-alcoholic fatty liver disease and abnormal liver function tests. Guidelines were signposted in existing Trust newsletters to primary care. Teaching sessions were held in face-to-face groups in our Postgraduate Education Centre on a four monthly basis. Three or four short lectures were given. Online, single topic lectures were arranged in addition. Each hepatologist was asked to provide one online lecture per year.

Expanding the hepatology day unit

The unit had already established a day unit service three times a week to help achieve reduced length of stay, provide day care paracentesis and to prevent presentation via the emergency department (ED). We realised the potential of expansion of the day unit to facilitate early discharge of inpatients with rapid follow up, to manage newly diagnosed hepatological and hepatobiliary conditions which require expedited and recurrent reviews, and to facilittate blood tests. This successfully reduced the inpatient bed pressures and the requirement for repeated outpatient appointments. This dramatically reduced the admission of patients via ED for paracentesis. A new standard operating procedure was finalised, incorporating referral pathways from elsewhere in the hospital, active 5 days per week. This was especially useful during COVID period allowing us to avoid inpatient admissions.

Preparing a strategy to address demand and capacity

During this period, the requirement for another hepatology consultant became clear, mainly to deal with overdue follow-ups and to provide hepatology support to the alcohol care team (which resides in general medical directorate). We successfully submitted a business case with supported programmed activities from the alcohol care team and appointed a new consultant. Two week wait hepatology and hepatobiliary caseload was significant, and we set up a pathway with support of the hepatobiliary clinical nurse specialist (CNS) for a same-day investigation pathway (outpatient review by senior clinician, immediate blood tests and imaging, followed by a CNS telephone clinic the same afternoon with preliminary results). Specialist multidisciplinary clinics for various patient groups with conditions including chronic liver disease (CLD), autoimmune hepatitis and inflammatory bowel disease-primary sclerosing cholangitis (IBD-PSC) were established and consolidated. During our review of outpatient demand and capacity, patient cohorts at lower clinical risk (eg inactive hepatitis B, NAFLD without advanced fibrosis) that could be managed safely in the community with support from an integrated hepatology service in collaboration with primary care physicians were identified. Modelling this initiative demonstrated that it would drastically reduce the requirement for outpatient follow-up, albeit with the need to dedicate consultant sessions. A business case has been formulated and is in discussion at clinical commissioning group level.

Creating a database and uploading evidence

Uploading the evidence was demanding and time-intensive. In the absence of a specific administrative role, the IQILS trained hepatologist uploaded evidence in batches throughout the process. Team members were asked to add evidence for which they had taken responsibility into a central shared file (eg research outputs, audits, teaching presentations). We concluded that to prospectively maintain a database of evidence showing that the unit is engaged in guideline development, teaching and feedback, administrative support is essential. A business case for this role was submitted and accepted, active from the next financial year. We have now successfully appointed a joint IQILs and JAG coordinator, who is being trained appropriately.

Preparing for and hosting the site visit

One year after IQILS level 1 accreditation, the date for the IQILS 2 site visit was agreed. All team members were asked to make themselves available. The team was asked to identify a trainee and a nurse specialist for one-to-one interviews. The clinical director was required to meet with the assessors for an initial overview presentation and a subsequent one-to-one interview. At the end of the day the assessors gave feedback. Level 2 accreditation could not be given on the day and the reasons for this were explained. The main reasons for deferment were requirement for an up-to-date strategic document, separation of governance processes for hepatology department and completion of required audits. A timeframe was given, confirmed in writing shortly afterwards. Completing the audits and an up-to-date strategic document was relatively easy but separation of governance process for hepatology proved interesting and challenging and has been explained in detail below. These were addressed over the following two months, and evidence that they had been achieved was uploaded. Following this, level 2 accreditation was given.

Reorganisation of governance structure and processes following deferment

IQILS requires the identification of hepatology-specific risks or incidents, and this was a challenge. Processes had grown organically since the establishment of a separate gastroenterology department outside general medicine decades before, and were not designed to separate different streams of information. Additionally, processes necessarily loop into 'central' governance groups which see hepatology as a part of a larger gastroenterology department. Therefore, the team had to assure the assessors that hepatology risks were made visible to it, and that learning points could be recorded and actions completed.

Many different streams of information and intelligence exist, including notified patient safety incidents, formal complaints, PALS referrals, organised feedback and mortality reviews. There are also several governance and safety committees in the Trust that sit alongside or above the hepatology group, for example the Trust Mortality Review Group and the Serious Incident Assurance Panel: such complexity is likely to hold true for many organisations. Hepatology-specific issues are discussed in three venues: departmental governance committee, directorate governance committee (if risks or consequences are significant and resolution requires higher level decisions) and a monthly hepatology business meeting. Patient feedback is summarised and reported to the gastroenterology governance committee, and consideration as to

Table 1. Main service changes driven by need to align with IQILS standards

IQILs domain	Service changes	Benefits
Leadership and operational delivery	Monthly business meetings instituted	Multidisciplinary strategic discussion and action plans instituted
	HPB cancer pathway	Streamlined the 2-week-wait HPB pathway
		Same day clinician review, followed by imaging and blood tests and telephone appointment with CNS in the afternoon with results and plans.
Person centred care	Bespoke hepatology patient feedback	Service-focused feedback leading to service improvements
	Dedicated liver helpline (email)	Turnaround time 24–48 hours
		Excellent feedback from patients
		Reduced complaints
	Patient forum	Quarterly patient forum
		Virtual platform
		Numerous improvements, such as dedicated liver helpline established based on feedback
Risk and patient safety	Hepatology governance	Monthly mortality and morbidity meetings
		Hepatology governance issues discussed at directorate level and fed back in business meeting
Clinical effectiveness	Multidisciplinary specialist clinics	Improved patient experience and compliance due to multidisciplinary involvement
		Reduced need for multiple appointments through joint clinics (IBD-PSC, CLD-dietician-CNS)
	Collaborations	Joint MDTs and clinics with haematology, cardiology, bariatric service, addiction service and oncology
		Regional HPB endoscopy referral centre
		Advice and guidance for primary care
Workforce	Education	Primary care education sessions regarding referral pathways and management of patients in community
		ED/ acute medicine sessions
	Appointments	Locum consultant
		Hepatology pathway coordinators
		IQILs coordinator
Systems to support clinical service delivery	Day unit expansion	Led to 5-day service
		Decreased length of stay and admissions to ED
		Day care paracentesis for all patients known to our service (no ED admissions in the last year)
	Future development	Expansion of hepatology CNS pool for IP care
		Community hepatology project
		Establishment of pregnancy liver and transition clinics
		Dedicated palliative care nurse (business case in)
		Expansion of R&D portfolio

CLD = chronic liver disease; CNS = clinical nurse specialist; ED = emergency department; HPB = hepato-pancreatico-biliary; IBD = inflammatory bowel disease; IP = inpatient; MDT = multidisciplinary team; PSC = primary sclerosing cholangitis; R&D = research and development.

how the service should respond occurs in the hepatology business meeting. Complaints specific to hepatology (eg care on ward, clinic arrangements) are also taken to the hepatology business meeting after initial collation via QIPS managers and trend review in the governance committee. A monthly hepatology mortality and morbidity meeting was set up and this was fed back to directorate governance group ensuring information flow between both the groups. ■

Summary

Achieving IQILS level 2 took 2 years from initial attendance at the orientation session to final notification. The process improved quality from the outset, in our case by formalising business meetings where ideas, challenges and strategies could be discussed and action plans agreed. Early changes included a more structured approach to patient feedback and a sustainable model for ensuring that this improvement loop was maintained. Another early benefit was the opportunity to gain a better overall perspective of current services. Over the years numerous activities had developed, led by enthusiastic individuals or in collaboration with other departments (for instance specialist haematology–hepatology or dermatology–hepatology clinics), and a full record was beneficial in representing the service.

The most challenging areas were, as described, allocating resource to the administrative requirements, and establishing a realistic strategy for tackling clinic backlogs. This was not helped by the outbreak of the pandemic. Regarding administrative support, we had to develop a business case for this, citing the indefinite need for prospective evidence gathering, coordination and organisation in a database. The parallels with the JAG process were helpful in this regard and we recently successfully recruited a coordinator. Changes to service are presented in Table 1.

Our experience confirms that achieving full IQILS accreditation is possible in a relatively short time frame. It does require agreed prioritisation among all specialist and the management groups. We would advise other departments planning to commence this process to identify who will have overall ownership of evidence gathering, but also delegate effectively among members of the group. Our tips for other services are summarised in Box 1.

Box 1. Tips for achieving IQILS accreditation

- Ensure clear vision and leadership
- Gain early buy-in from management
- Ensure clear delegation of tasks with timescales
- Identify overall ownership for evidence gathering
- Ideally, recruit an IQILs coordinator

References

1 Royal College of Physicians. *RCP launches IQILS accreditation scheme*. RCP, 2017. www.rcplondon.ac.uk/news/rcp-launches-iqils-accreditation-scheme.

2 Improving Quality in Liver Services Standards. *Full accreditation standards - level one and two*. IQILS, 2019. Available from www.iqils.org/IQILS-standards [Accessed 18 April 2023].

Address for correspondence: Sreelakshmi Kotha, Department of Gastroenterology, Guy's and St Thomas' Hospital, Westminster Bridge Road, London, SE1 7EH, UK.
Email: sreelakshmi_kotha@yahoo.com.
Twitter: @sreeL_k; @philaberry